MONTANA BREAST & CERVICAL HEALTH PROGRAM

MONTANA MEDICAL BILLING

COMPLETING THE HCFA-1500 FORM

All claims for the Montana Breast and Cervical Health Program (MBCHP) should be submitted to:

Montana Medical Billing
MBCHP Unit
P. O. Box 5865
Helena, MT 59604

Claims may be submitted on HCFA-1500 forms, or on UB-92 forms.

MBCHP is the payer of last resort. If a patient has private insurance and\or Medicare, you must bill the other insurance and\or Medicare first, and attach a copy of the Explanation of Benefits Form(s) to the claim you submit to MBCHP.

MBCHP will accept electronic filing of HCFA-1500 Forms. If you are interested in filing electronically, please contact Montana Medical Billing at (888) 227-7065.

Claims will be processed for payment twice monthly. An Explanation of Benefits will accompany each payment.

Instructions for completing the HCFA-1500 claim form have been divided into three sections for easier reference. The sections are:

Section 1. MBCHP Only Claims

Section 2. Medicare\MBCHP and Third Party(Private Insurance)\MBCHP Claims

Section 3. Third Party\Medicare\MBCHP Claims

Fields with an * are required fields; all others are optional for MBCHP purposes. Refer to the HCFA-1500 (12/90 version) claim form for location of the numbered fields. If you have questions, please contact Montana Medical Billing MBCHP Unit toll free at (888) 227-7065.

SECTION 1. MBCHP ONLY CLAIMS

1. MBCHP ONLY CLAIMS			
Required Field	**Field Number**	**Field Name**	**Instructions**
*	1a	Insured□s ID Number	Enter the patient's Social Security Number
*	2	Patient□s Name	List the patient's last name, first name, and middle initial
*	3	Patient□s DOB & Sex	Enter the patient's date of birth (MM/DD/YYYY) and sex
	5	Patient□s Address	Enter the patient's address
*	11d	Is there another Health Benefit Plan?	Check "NO" (If the answer to this question is "Yes", you must follow the appropriate instructions in section 2 or 3)
*	21	Diagnosis or Nature of Illness or Injury.	Enter the appropriate ICD-9-CM diagnosis codes. Enter up to 4 codes in priority order (primary, secondary, etc.)
*	24a	Date(s) of Service	Enter date(s) of service (MM/DD/YYYY) for each procedure, service or supply
*	24b	Place of Service	Enter the appropriate place of service from the following choices: 11 Office 22 Outpatient Hospital 71 Public Health Clinic 81 Independent Laboratory 99 Other Unlisted Facility
	24c	Type of Service	Leave blank or enter 0
*	24d	Procedures, Services or Supplies	Enter the appropriate CPT code for the procedure, service or supply. When applicable, enter the appropriate CPT modifier **Please Note: Only the procedure codes listed in Appendix H are covered by the MBCHP**

1. MBCHP ONLY CLAIMS			
*	24e	Diagnosis Code	Enter the diagnosis code reference number (1,2,3 or 4) shown in Field 21 as they apply to each line of the claim **ONLY THE SPECIFIC REFERENCE NUMBERS WILL BE ACCEPTED. Do not enter the ICD-9-CM diagnosis code in this field**
*	24f	Charges	Enter the usual and customary charges
*	24g	Days or Units	Enter the number of units for the procedure and date(s) of service billed on this line
*	29	Amount Paid	Leave blank or enter $0.00. If payment has been received by a third party, please see section II and/or III
*	30	Balance Due	Enter the balance due- this amount is the same as Field 28
*	31	Signature of Physician or Supplier and Date	**Signature:** This field must contain either: a. the provider's actual signature b. authorized agent's signature c. facsimile (rubber stamp) signature, or d. a computer generated name **Date:** This field must contain the date of the claim submission in MM/DD/YYYY format. (The submission must be dated on or after the last date of service on the claim)
*	32	Name & Address of Facility where service rendered	Enter the name and address of the person, organization or facility performing the services
*	33	Physician's, Supplier's Billing Name, Address, Zip Code, Phone # and **PIN#**	Enter the name, address, phone number, and **MBCHP Provider Number** of the physician or supplier who furnished services

Section 2. Medicare\MBCHP and Third Party (Private Insurance) \MBCHP Claims

Follow instructions in Section 1 (page 2) with the following exceptions:

2. MEDICARE\MBCHP AND THIRD PARTY OR PRIVATE INSURANCE\MBCHP CLAIMS			
Required Field	**Field Number**	**Field Name**	**Instructions**
*	1a	Insured□s ID Number	Enter the Medicare or Third Party Liability identification number
	4	Insured□s Name	Enter the name of the insured, except when the insured and patient are the same - then the word "SAME" may be entered
	7	Insured□s Address	Enter the insured□s address and telephone number, except when the address and telephone number are the same as the patient - then the word "SAME" may be entered
*	10d	Reserved for Local Use	Enter the Patient□s Social Security Number
*	11c	Insurance Plan Name or Program Name	Enter the name of the other insurance plan or program name (i.e. Medicare, BC\BS)
*	11d	Is there another Health Benefit Plan?	Check "YES"
*	29	Amount Paid	Enter the amount paid by other insurance **only.** Do not enter Medicare payment amount in this field. Medicare payment amount will be determined from the Explanation of Medicare Benefits (EOMB) attached to the claim
*	30	Balance Due	Enter the balance due

Section 3. Third Party\Medicare\MBCHP Claims

Follow instructions in Section 1 (page 2) with the following exceptions:

3. THIRD PARTY\MEDICARE\MBCHP CLAIMS			
Required Field	**Field Number**	**Field Name**	**Instructions**
*	1a	Insured□s ID Number	Enter the Medicare identification number
	4	Insured□s Name	Enter the name of the insured, except when the insured and patient are the same - then the word "SAME" may be entered
	7	Insured□s Address	Enter the insured□s address and telephone number, except when the address and telephone number are the same as the patient - then the word "SAME" may be entered
*	10d	Reserved for Local Use	Enter the Patient□s Social Security Number
*	11	Insured□s Policy Group or FECA Number	Enter the primary (Third Party) payer□s identification number
*	11c	Insurance Plan Name or Program Name	Enter the name of the primary payer
*	11d	Is there another Health Benefit Plan?	Check "YES"
*	29	Amount Paid	Enter the amount actually paid by other insurance coverage or Medicare. Do not include any adjustment amounts in this field
*	30	Balance Due	Enter the balance due

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COMPLETING THE UB-92 FORM

Instructions for completion of the UB-92 Form must follow the Montana Medicaid requirements. Please refer to the Montana Medicaid billing instruction manual provided by Medicaid. Where instructions refer to Montana Medicaid, substitute Montana Breast & Cervical Health Program.

If you need a standard UB-92 manual, (for overall information) they can be obtained from the Montana Hospital Association (MHA) by calling (406) 442-1911. There is a charge for purchase of the manual from the MHA.

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